Understanding the medical needs of migrants, refugees and asylum seekers

The World Health Organization draft global action plan aims to strengthen health services for asylum seekers and refugees in host countries. Addressing the healthcare needs of this population can be daunting but healthcare professionals can have a hugely positive impact by providing high quality, trauma-informed care and understanding the barriers these people may face in accessing care. This editorial unpicks the complexities healthcare professionals face when working with this vulnerable group.

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Introduction

We are in the midst of the largest population movement since the second world war, with forced displacement at its highest ever level globally (United Nations High Commissioner for Refugees, 2019). Conflict, persecution, political instability and climate change are major drivers of this migration. The United Nations High Commissioner for Refugees (2021) estimated that in 2020, about 82.4 million people were forcibly displaced. In 2021 in the UK alone there were 48 540 asylum applications (Home Office, 2021), with new arrivals in recent months from Afghanistan and Ukraine highlighting the plight of migrants.

Asylum seekers and refugees are likely to have significant underlying physical and mental health conditions, so providing adequate healthcare should be a priority in any host country. However, there are significant challenges in delivering this because of the potentially complex needs of people and the many barriers to accessing healthcare.

Stages of migration

Visualising and reflecting on the three stages of the person's journey – pre-migration, transit and post-migration – offers valuable pointers as to possible health needs and provides a structure in which to work. Experiences in each of these three stages of migration may act in a cumulative way to shape health needs and health behaviours.

Pre-migration

People may be fleeing conflict, oppression, persecution, torture or imprisonment. They may have also been the victim of other forms of violence such as domestic abuse, sexual and gender-based violence, human trafficking, slavery or forced marriage. They may have come from areas where certain diseases are endemic, and conditions of poor sanitation and overcrowding increase transmission rates and severity of disease. Some may be escaping poverty, with famine or food insecurity causing malnutrition. In all these situations, it is possible that there has either been non-existent or limited healthcare.

During migration

The migration route is important and questions should be asked about the length of time and circumstances of any stay in countries travelled through. To reach relative safety, a person is likely to have endured perilous situations where environmental hazards (eg extremes of cold or heat, infection, lack of food or healthcare) and the threat or actuality of physical violence can add to previous trauma and ill health. Stays in refugee camps, where nutrition and sanitation are likely to have been poor and violence prevalent, can add further damage. The possibility of exploitation should be explored, as human trafficking is likely during these journeys.

Post-migration

For many migrants the situation in the host country can add to the burden of poor health. Isolation, with loss of family, friends, culture and community support, alongside poverty,

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housing insecurity, and a complicated and uncertain asylum process, can compound issues. A lack of choice and control and an inability to work against a backdrop of media hostility, racism and discrimination can add to mental ill health. Barriers to accessing health and legal systems and the very real possibility of immigration detention, other institutionalised accommodation and/or prison can all add to vulnerabilities. Victims of trafficking, even after escape from an exploitative situation, live in fear of threats and reprisals from their traffickers, as well as with the long-term effects of the control mechanisms that have been used against them. The risks of re-trafficking are high because of physical and psychological vulnerabilities overlaid on a difficult economic and social situation.

Disclosure of trauma

Disclosure of physical and psychological traumas can be difficult and takes time and trust. Victims of trafficking have particular issues with disclosing their experiences and may not identify themselves as victims (Hunt et al, 2020). Healthcare professionals should not be shy about asking direct questions about an individual's history, but must do so in an empathetic, trauma-informed way and be mindful of the risks of re-traumatisation (Witkin and Robjant, 2018).

Medical needs

Communicable diseases

Migrants may be at greater risk of communicable disease because of the prevalence of such conditions in their country of origin or during transit. Transmission and illness from exposure to communicable disease may be exacerbated by malnutrition, poor sanitation, overcrowding or stress. Lack of access to full vaccination schedules may result in childhood diseases not usually seen in host countries.

Tuberculosis (active and latent), HIV and hepatitis B/C need to be considered as well as tropical (eg malaria and parasitic infections) and general infectious diseases. The UK Health Security Agency (https://www.gov.uk/government/organisations/uk-health-security-agency) offers further advice and guidance on screening for these conditions.

Non-communicable diseases

Risk factors for non-communicable diseases in low and middle income countries are now similar to those in developed countries, causing an increase in the prevalence of diabetes, hypertension, cardiovascular disease and chronic obstructive pulmonary disease. Lack of or interrupted access to screening and treatment throughout all stages of the migrant journey means that migrants are more likely to present with advanced disease and complications of non-communicable diseases including cancers.

Nutritional deficiencies, genetic disease (such as sickle cell, thalassaemia), poor oral health and non-infectious environmental hazards (such as lead poisoning) may need to be considered.

Sexual and reproductive health

Female migrants often have specific needs in terms of reproductive and sexual health. They may not have had access to contraception, breast, cervical or sexually transmitted disease screening. People who have come from areas where female genital mutilation is prevalent should be sensitively asked about this (World Health Organization, 2022a).

Those who are pregnant have multiple risk factors for increased pregnancy-related morbidity and mortality (Heslehurst et al, 2018). They often present late to maternity care, often to emergency services without prior screening or antenatal care.

Women who have experienced forced migration are at increased risk of sexual and gender-based violence and risks of sexual violence can increase after migration to destination countries. Sexual torture is reported by 63–80% of female and 25–56% of male torture victims (Lunde and Ortmann, 1990; Busch et al, 2015). Sexual violence is under-reported and is always difficult to disclose. This is particularly the case for male refugees as it may transgress their normal cultural identity.

Physical consequences of abuse

- Multiple, partially healed and untreated injuries may be a cause of significant pain and disability. Fractures, burns, dental and facial injuries, tendon, ligament and nerve damage are common (Office of the United Nations High Commissioner for Human Rights, 2004; Peel et al, 2009)
- Sequelae of head injuries should be considered, including headaches, post-concussional syndromes, post-traumatic epilepsy and cognitive difficulties
- Consequences of sexual and gender-based violence can include sexually transmitted infections, pelvic inflammatory disease, pregnancies, and damage to the ano-genital area including soft tissue injuries, fistulae and perforations
- Physical consequences of captivity and poor hygiene may be noted including malnourishment and communicable diseases
- A myriad of exploitative work-related injuries (environmental and/or industrial) may be seen in victims of trafficking .

Mental health

Almost all people who have been affected by emergencies such as conflict or environmental disasters will experience psychological distress. The World Health Organization (2022b) notes that in a humanitarian crisis, the prevalence of depression and anxiety more than doubles. Asylum seekers and refugees may have been exposed to multiple traumatic events and may have a variety of emotional responses related to trauma and grief, as well as diagnosable mental illnesses.

In a systematic review of asylum seekers and refugees, Blackmore et al (2020) reported high prevalence rates of post-traumatic stress disorder (31%) and depression (31%) which appeared to persist for many years after displacement. Other important diagnoses include anxiety disorders, psychosis, alcohol or substance use disorders, suicidal or self-harm behaviours, and personality disorders.

Psychosomatic presentations are common. Physical and psychological issues are deeply entwined in asylum seekers and refugees, for example physical injuries can cause scarring, disfigurement, pain and disability which can act as a constant reminder of the violence and trauma experienced.

It is important to remember that mental illness may not be expressed in the same way by these groups as it is in the UK and that western psychological concepts are not universally applicable.

Healthcare barriers

This population experiences significant barriers to accessing healthcare post-migration (Kang et al, 2019) and these need to be understood in order to improve services. These include:

- Difficulty understanding complex healthcare entitlements
- Difficult administrative procedures and documentation requirements
- A lack of training around the complex health needs of forced migrants, including asylum seekers and refugees
- Lack of time in an under-resourced and overstretched health service
- Literacy issues and language barriers
- Frequent accommodation moves (including immigration detention and contingent accommodation) (Jones et al, 2022) can disrupt healthcare provision
- Travel costs
- Difficulty accessing online and telephone services, and digital poverty (Knights et al, 2021)
- Cultural differences in understanding physical and mental health issues
- Lack of trust of authority figures (including medical professionals)
- Fear of disclosing information because of the risks of negative asylum decisions and because of threats from traffickers
- Disclosure causing re-traumatisation including flashbacks and dissociation
- Trauma causing challenges with memory
- Loss of ‘agency’ and autonomy, as well as the threat of stigma and shame.

Key points

- Migration, specifically forced displacement, is at its highest ever level globally.
- Forced migrants including asylum seekers and refugees often have multiple and complex health needs.
- Health needs may be cumulative and arise from issues pre-migration, during transit and post-migration.
- Providing adequate healthcare can be a challenge for healthcare professionals.
- Asylum seekers and refugees encounter significant barriers to accessing healthcare.
- It is important to recognise and address the health needs of asylum seekers and refugees, both for individual clinicians and for the development of improved service structures for these populations.
- Always work in a trauma-informed way and remember that every contact is an opportunity to build trust.

Conclusions

When working with migrants, refugees or asylum seekers, it is vital to work in a trauma-informed way, to consider the cumulative nature of possible health consequences from each stage of the person's journey, and to particularly consider the physical and psychological consequences of possible human rights violations, such as torture, trafficking and other forms of interpersonal violence. Healthcare professionals need to understand and bear in mind the difficulties that patients have in accessing healthcare, and address their services and methods of working to mitigate these.

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